STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 86750-001**
v

Priority Health
Respondent
_____/

Issued and entered
This 21st day of April 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On February 7, 2008, XXXXX, on behalf of her minor daughter XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. After a preliminary review of the material submitted the Commissioner accepted the request on February 14, 2008.

The Petitioner had health care coverage from Care Choices and her benefits are defined in the Care Choices certificate of coverage (the certificate). On March 27, 2007, Care Choices surrendered its certificate of authority and is no longer licensed to conduct business as a health maintenance organization. Priority Health, which acquired the assets and obligations of Care Choices and is now responsible for processing Care Choices claims, is the respondent in this external review. In this order, the certificate and medical policy quoted were documents that applied to the Petitioner's Care Choices coverage at the time the services at issue in this matter were performed.

Initially this case appeared to involve only contractual issues so the Commissioner did not assign it to an independent review organization. Upon further evaluation the Commissioner

determined this case would benefit from a medical review by an outside expert and assigned an IRO. On March 14, 2008, the IRO completed its review and sent it to the Office of Financial and Insurance Services (OFIS).

II
FACTUAL BACKGROUND

Born October 14, 2004, the Petitioner suffered an in utero stroke causing cerebral palsy that resulted in right side weakness. She was referred for physical therapy (PT) and occupational therapy (OT) to improve her range of motion in her right side. Between April 1 and December 31, 2006, she received therapy from XXXXX. Priority Health denied coverage for these services.

The Petitioner appealed. After the Petitioner exhausted the internal grievance process, Priority Health maintained its denial and sent its final adverse determination letter dated December 28, 2007.

III
ISSUE

Was Priority Health's denial of coverage for physical and occupational therapy visits correct under the terms of the certificate?

IV
ANALYSIS

Petitioner's Argument

The Petitioner's mother says that the therapy has resulted in great improvement. She believes Priority Health's refusal to authorize and cover the therapy may impede the progress the Petitioner has made and she may possibly even regress. The mother says she cannot understand why Priority Health will not cover the Petitioner's therapy when her past health care insurers did. The mother notes that the Petitioner's therapist said it is standard procedure to provide for a 12-visit evaluation period to determine whether or not physical therapy will be of benefit yet Priority Health did not even offer the 12 visits.

The Petitioner says that she is showing significant improvement and her physical therapist determined further therapy is medically necessary. She believes that PT and OT should be covered by Priority Health -- at least the therapy provided in 2006.

Priority Health's Argument

Priority Health says its coverage of PT and OT is limited to short term treatment for an acute condition or injury. Priority Health's denial was based on the following provision of the certificate, which describes therapy and rehabilitation benefits:

> **5.7 Short Term Physical or Medical Rehabilitative Services**
>
> Subject to the limitations and exclusions of this Certificate and applicable riders, HMO covers the following services for acute conditions requiring short-term therapy. Therapy is covered if the therapy is expected to result in significant functional improvement within sixty (60) days of the onset of treatment. All such therapy requires approval in advance by the HMO. Significant functional improvement is defined as restorative improvement to reasonable function as determined by HMO. Covered services include:
>
> - Physical therapy
> - Speech therapy
> - Occupational therapy
> - Cardiac rehabilitation
> - Pulmonary rehabilitation
>
> * * *
>
> HMO does not cover maintenance type of therapies of any kind or therapies for chronic conditions. [Emphasis added]

Priority Health's medical policy entitled "Physical Therapy/Occupational Therapy," further explains its coverage of PT and OT:

> **B. Policy**
>
> * * *
>
> Coverage is available for SHORT-TERM treatment of an acute condition or injury of recent onset if the following criteria are met:
>
> * * *
>
> (5) The patient's condition must be subject to significant functional improvement as a result of PT and/or OT, *within 60 days* of onset of treatment.
>
> * * *
>
> ***Limitations and Exclusions***

> The following physical/occupational therapy services are not covered: (not an all inclusive list)
>
> 1. Chronic conditions (see 6.16 (22) on page 9 of this policy for exceptions).
>
> * * *
>
> 5. Developmental impairments such as cerebral palsy, mental retardation and developmental delay (see 6.16 (22) on page 9 of this policy for exceptions).

Priority Health believes it correctly denied coverage because PT and OT for chronic conditions are excluded under the terms of the certificate.

Commissioner's Review

The focus of this analysis is whether Priority Health's denial of coverage was correct. The certificate contains provisions applicable to the Petitioner's request for coverage of PT/OT services. Section 5.2 of the subscriber certificate includes this information:

> **5.2 Covered Services—General**
>
> *** * ***
>
> **Requirements for Covered Services**
>
> Services covered by HMO must be:
>
> (1) Provided by the PCP or arranged by the PCP or Participating Specialist and approved in advance by HMO, and
>
> (2) Medically necessary, and
>
> (3) A covered benefit, and
>
> (4) Not specifically excluded from coverage, and
>
> **(5)** Provided by a HMO Participating Provider, except in emergencies. [Underlining added]

The certificate also has this exclusion from coverage:

> **6.16 General Limitations and Exclusions**
>
> The following are not Covered Services:
>
> * * *
>
> (22) Physical, occupational and speech therapy necessary or designed to treat developmental delays or congenital abnormalities and conditions; to treat chronic conditions; to treat chronic conditions; or to maintain current function.

> This exclusion does not apply when (i) no previous treatment has been received by the Member and the Member's capabilities have recently deteriorated; (ii) or intervening medical complications have affected physical function.

To help the Commissioner resolve the issue of whether Priority Health's denial of coverage for PT and OT therapy was correct, the matter was assigned to an independent review organization (IRO) for the recommendation of an expert. The IRO physician reviewer is certified by the American Board of Pediatrics with a subspecialty in adolescent medicine; certified by the American Board of Preventive Medicine; published in peer reviewed medical literature; and in active practice. The IRO reviewer recommended upholding Priority Health's denial of coverage. The IRO reviewer said:

> After review of the documentation submitted for review, it is the determination of this reviewer that medical necessity has been established for this enrollee's therapy services; however, [Priority Health] correctly denied these services based on exclusion language.
>
> * * *
>
> According to [Priority Health's] Physical Therapy/Occupational Therapy medical policy, coverage for physical and occupational therapy services were properly denied as an exclusion. The physical therapy and occupational therapy would appear to be specifically excluded under section 6.16 (22)….
>
> * * *
>
> Cerebral palsy in any form must be considered a chronic condition and cannot be argued otherwise in this case. Furthermore, this is clearly a "congenital condition" since it is present from birth and possibly resulted from an in utero cerebral vascular accident. The enrollee's Magnetic Resonance Imaging (MRI) scan is suggestive of this idea. * * * Furthermore, cerebral palsy clearly results in developmental delays as a result of the child having difficulty performing certain motor and other tasks. Delay in achieving "developmental benchmarks" is another factor supporting CP as a chronic congenital condition which is specifically excluded under the enrollee's plan language.
>
> * * *
>
> The medical policy also has exclusion language which specifically states that chronic conditions are not covered for physical and occupational therapy services for "developmental impairments such as cerebral palsy." It is evident to this reviewer that the health plan envisions CP as a chronic condition and specifically excludes coverage of physical and occupational therapy for this condition.

The Commissioner accepts the IRO reviewer's conclusion that cerebral palsy is a

chronic condition. Further, the IRO reviewer's conclusion that the PT and OT are excluded for chronic conditions is in accord with the Commissioner's reading of the certificate. Under Michigan law, health maintenance organizations like Priority Health are not required to provide PT and OT services; if they do provide them, they may exclude coverage, as Priority Health has done here, for chronic conditions.

In summary, the Commissioner finds that Priority Health's denial of the Petitioner's treatment was correct because the Petitioner has a chronic condition and PT and OT for chronic conditions are excluded from coverage. The Commissioner finds that Priority Health's denial is consistent with the certificate.

V
ORDER

The Commissioner upholds Priority Health's December 28, 2007, final adverse determination in this case. Priority Health correctly denied coverage for the Petitioner's PT and OT services under the terms of the certificate.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the Circuit Court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.